



THE FDA MEDICAL PRODUCTS REPORTING PROGRAM

For use by user-facilities,  
distributors and manufacturers for  
MANDATORY reporting

Page \_\_\_\_ of \_\_\_\_

Form Approved: OMB No. 0910-0291 Expires: 11/30/99  
See OMB statement on reverse

Mfr report #
UF/Dist report #
FDA Use Only

### A. Patient information

1. Patient identifier	2. Age at time of event: or _____ Date of birth:	3. Sex <input type="checkbox"/> female <input type="checkbox"/> male	4. Weight _____ lbs or _____ kgs
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### B. Adverse event or product problem

1. <input type="checkbox"/> Adverse event and/or <input type="checkbox"/> Product problem (e.g., defects/malfunctions)	
2. Outcomes attributed to adverse event (check all that apply) <input type="checkbox"/> death _____ (mo/day/yr) <input type="checkbox"/> life-threatening <input type="checkbox"/> hospitalization – initial or prolonged	
<input type="checkbox"/> disability <input type="checkbox"/> congenital anomaly <input type="checkbox"/> required intervention to prevent permanent impairment/damage <input type="checkbox"/> other: _____	
3. Date of event (mo/day/yr)	4. Date of this report (mo/day/yr)

5. Describe event or problem

6. Relevant tests/laboratory data, including dates

7. Other relevant history, including preexisting medical conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

### C. Suspect medication(s)

1. Name (give labeled strength & mfr/labeler, if known) #1 _____ #2 _____		3. Therapy dates (if unknown, give duration) from/to (or best estimate) #1 _____ #2 _____
2. Dose, frequency & route used #1 _____ #2 _____		4. Diagnosis for use (indication) #1 _____ #2 _____
6. Lot # (if known) #1 _____ #2 _____	7. Exp. date (if known) #1 _____ #2 _____	5. Event abated after use stopped or dose reduced #1 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply #2 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply
9. NDC # – for product problems only (if known) _____		8. Event reappeared after reintroduction #1 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply #2 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply
10. Concomitant medical products and therapy dates (exclude treatment of event)		

### D. Suspect medical device

1. Brand name	
2. Type of device	
3. Manufacturer name & address	4. Operator of device <input type="checkbox"/> health professional <input type="checkbox"/> lay user/patient <input type="checkbox"/> other: _____
6. model # _____ catalog # _____ serial # _____ lot # _____ other # _____	5. Expiration date (mo/day/yr) 7. If implanted, give date (mo/day/yr) 8. If explanted, give date (mo/day/yr)
9. Device available for evaluation? (Do not send to FDA) <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> returned to manufacturer on _____ (mo/day/yr)	

10. Concomitant medical products and therapy dates (exclude treatment of event)

### E. Initial reporter

1. Name & address	phone #
2. Health professional? <input type="checkbox"/> yes <input type="checkbox"/> no	
3. Occupation	4. Initial reporter also sent report to FDA <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk



FDA Form 3500A

Submission of a report does not constitute an admission that medical personnel, user facility, distributor, manufacturer or product caused or contributed to the event.

PLEASE TYPE OR USE BLACK INK

# Medication and Device Experience Report

(continued)

Refer to guidelines for specific instructions

Submission of a report does not constitute an admission that medical personnel, user facility, distributor, manufacturer or product caused or contributed to the event.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service • Food and Drug Administration

Page \_\_\_\_ of \_\_\_\_

FDA Use Only

F. For use by user facility/distributor—devices only			
1. Check one <input type="checkbox"/> user facility <input type="checkbox"/> distributor		2. UF/Dist report number	
3. User facility or distributor name/address			
4. Contact person		5. Phone Number	
6. Date user facility or distributor became aware of event (mo/day/yr)		7. Type of report <input type="checkbox"/> initial <input type="checkbox"/> follow-up # _____	8. Date of this report (mo/day/yr)
9. Approximate age of device	10. Event problem codes (refer to coding manual) patient code _____ - _____ - _____ device code _____ - _____ - _____		
11. Report sent to FDA? <input type="checkbox"/> yes _____ (mo/day/yr) <input type="checkbox"/> no		12. Location where event occurred <input type="checkbox"/> hospital <input type="checkbox"/> outpatient diagnostic facility <input type="checkbox"/> home <input type="checkbox"/> ambulatory surgical facility <input type="checkbox"/> nursing home <input type="checkbox"/> outpatient treatment facility <input type="checkbox"/> other: _____ specify	
13. Report sent to manufacturer? <input type="checkbox"/> yes _____ (mo/day/yr) <input type="checkbox"/> no			
14. Manufacturer name/address			

G. All manufacturers			
1. Contact office – name/address (& mfng site for devices)		2. Phone number	
4. Date received by manufacturer (mo/day/yr)		3. Report source (check all that apply) <input type="checkbox"/> foreign <input type="checkbox"/> study <input type="checkbox"/> literature <input type="checkbox"/> consumer <input type="checkbox"/> health professional <input type="checkbox"/> user facility <input type="checkbox"/> company representative <input type="checkbox"/> distributor <input type="checkbox"/> other: _____	
6. If IND, protocol #		5. (A)NDA # _____ IND # _____ PLA # _____ pre-1938 <input type="checkbox"/> yes OTC product <input type="checkbox"/> yes	
7. Type of report (check all that apply) <input type="checkbox"/> 5-day <input type="checkbox"/> 15-day <input type="checkbox"/> 10-day <input type="checkbox"/> periodic <input type="checkbox"/> Initial <input type="checkbox"/> follow-up # _____		8. Adverse event term(s)	
9. Mfr. report number			

H. Device manufacturers only	
1. Type of reportable event <input type="checkbox"/> death <input type="checkbox"/> serious injury <input type="checkbox"/> malfunction (see guidelines) <input type="checkbox"/> other: _____	2. If follow-up, what type? <input type="checkbox"/> correction <input type="checkbox"/> additional information <input type="checkbox"/> response to FDA request <input type="checkbox"/> device evaluation
3. Device evaluated by mfr? <input type="checkbox"/> not returned to mfr. <input type="checkbox"/> yes <input type="checkbox"/> evaluation summary attached <input type="checkbox"/> no (attach page to explain why not) or provide code: _____	4. Device manufacture date (mo/yr)
5. Labeled for single use? <input type="checkbox"/> yes <input type="checkbox"/> no	
6. Evaluation codes (refer to coding manual) method _____ - _____ - _____ - _____ results _____ - _____ - _____ - _____ conclusions _____ - _____ - _____ - _____	
7. If remedial action initiated, check type <input type="checkbox"/> recall <input type="checkbox"/> notification <input type="checkbox"/> repair <input type="checkbox"/> inspection <input type="checkbox"/> replace <input type="checkbox"/> patient monitoring <input type="checkbox"/> relabeling <input type="checkbox"/> modification/adjustment <input type="checkbox"/> other: _____	8. Usage of device <input type="checkbox"/> initial use of device <input type="checkbox"/> reuse <input type="checkbox"/> unknown
9. If action reported to FDA under 21 USC 360i(f), list correction/removal reporting number:	
10. <input type="checkbox"/> Additional manufacturer narrative    and/or    11. <input type="checkbox"/> Corrected data	

The public reporting burden for this collection of information has been estimated to average one-hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

DHHS Reports Clearance Office  
Paperwork Reduction Project (0910-0291)  
Hubert H. Humphrey Building, Room 531-H  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number."

Please DO NOT RETURN this form to this address.